Medical Services • Obstetrics

May 2007 • Bulletin 395

Contents

2007 CPT-4/HCPCS Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2007 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

CPT-4 Code Additions

Anesthesia
00625, 00626

Surgery
15002 – 15005, 15731, 17311 – 17315, 19300 – 19307, 22857, 22862, 22865, 25109, 25606 – 25609, 27325, 27326, 28055, 32998, 33202, 33203, 33254 – 33256, 33265, 33266, 33675 – 33677, 33724, 33726, 35302 – 35306, 35537 – 35540, 35637, 35638, 35883, 35884, 37210, 44157, 44158, 47719, 48105, 48548, 49324 – 49326, 49402, 49435, 49436, 54865, 55875, 55876, 56442, 57296, 57558, 58541 – 58544, 58548, 58957, 58958, 64910, 64911, 67346

Radiology
72291, 72292, 76776, 76998, 77001 – 77003, 77011 – 77014, 77021, 77022, 77031, 77032, 77051 – 77059, 77071 – 77077, 77080, 77081, 77371 – 77373, 77435

Pathology and Laboratory
82107, 83698, 83913, 86788, 86789, 87305, 87498, 87640, 87641, 87653, 87808

Medicine
92025, 94002, 94003, 94644, 94645

HCPCS Level II Code Additions

Radiopharmaceuticals
A9527

Injections and Drugs
C9233, J0348, J0894, J1740, J2248, J3243, J7187, J7311, J7611, J7613, J9035, J9261, Q4084 – Q4086

Surgery
G0392, G0393

CPT-4 Codes with Description Changes

Surgery
17000, 17003, 17004, 17110, 19120, 19361, 25600, 26170, 26180, 33681, 35301, 35501, 35506, 35509, 35601, 37216, 43842, 44211, 45400, 51720, 51999, 52204, 54161, 57295, 58950, 61107, 61210

Radiology
70540, 71275, 76506, 76536, 76604, 76645, 76700, 76770, 76856, 76880, 76940, 78350, 78700, 78707 – 78709, 78730, 78761

Pathology and Laboratory
82270 – 82272, 87088, 88104, 88106, 88107, 89060

Vaccines/Immunizations
90655 – 90658, 90669, 90700, 90702, 90714, 90715, 90718, 90732

Medicine
90761, 90766, 94620, 96415, 96423, 99251 – 99255, 99381, 99382, 99391

HCPCS Level II Codes with Description Changes

Implantable Devices and Supplies
C2620, L8614, L8689

Injections and Drugs
J0886, J9264

CPT-4 Code Deletions

Anesthesia
01995

Surgery
15000, 15001, 15831, 17304 – 17307, 17310, 19140, 19160, 19162, 19180, 19182, 19200, 19220, 19240, 21300, 25611, 25620, 26504, 27315, 27320, 28030, 31700, 31708, 31710, 33200, 33201, 33245, 33246, 33253, 35381, 35507, 35541, 35546, 35641, 44152, 44153, 47716, 48005, 48180, 49085, 54152, 54820, 55859, 56720, 57820, 67350

Radiology
75998, 76003, 76005, 76006, 76012, 76013, 76020, 76040, 76061, 76062, 76065, 76066, 76070, 76071, 76075 – 76078, 76082, 76083, 76086, 76088, 76090 – 76096, 76355, 76360, 76362, 76370, 76393, 76394, 76400, 76778, 76986, 78704, 78715, 78760

Medicine
91060, 92573, 94656, 94657, 95078

HCPCS Level II Code Deletions

Transportation Services
A0800

Radiopharmaceuticals
A9549

Injections and Drugs
C9225, J7188, S0116, X7484

Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) will phase in several changes which will impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service

- Courier services

- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

Processing Change Schedule
Processing changes to paper TARs will impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

May 2007	**August 2007**
Sacramento Medi-Cal Field Office	Fresno Medi-Cal Field Office
June 2007	San Bernardino Medi-Cal Field Office
Northern Pharmacy Section (Stockton)	San Diego Medi-Cal Field Office
Southern Pharmacy Section (L.A.)	San Francisco Medi-Cal Field Office
July 2007	**September 2007**
L.A. Medi-Cal Field Office	TAR Administrative Remedy Section
In-Home Operations South	In-Home Operations North

Incomplete TARs
CDHS Medi-Cal field offices and pharmacy sections <u>will be unable</u> to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, <u>and</u>

- Resubmit with a copy of the *Incomplete TAR Form* <u>on top</u> of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.

- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.

- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.

Processing Changes *(continued)*

- The patient is not Medi-Cal eligible.

- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.

- The requested service information is missing, invalid or invalid in length.

- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.

- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Please call 1-800-788-2949 for further information.

- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Please refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Adjudication Response
CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)

- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal

- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

Attachments
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

SSN on TARs
In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

If you have any questions regarding this information, please contact your local Medi-Cal field office or pharmacy section.

Processing Changes *(continued)*

National Provider Identifier (NPI) Number

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.
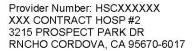

State of California - Health and Human Services Agency
Department of Health Services

ARNOLD SCHWARZENEGGER, Governor

CONFIDENTIAL
Medi-Cal Operations Division

ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
	Reason(s):	GEN: Modified, refer to comments							
	Comment(s):	Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
	Reason(s):	GEN: Denied, refer to comments							
	Comment(s):	Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
	Reason(s):	GEN: Deferred, refer to comments							
	Comment(s):	Comments from Field Office Consultant 4							

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

Update: CMS-1500 Claim Form Information

The Centers for Medicare & Medicaid Services (CMS) has notified Medi-Cal that there were incorrectly formatted versions of the revised *CMS-1500* claim form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files it received from the National Uniform Claim Committee's (NUCC) authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives, which do not comply with the form specifications. However, not all of the new forms are incorrect.

The following will help to properly identify whether providers have a version of the form that needs to be updated. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form, typically located in the lower right corner, signifying it is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form, signifying it is the August 2005 version.

Checking the information at the upper right hand corner of the form is the best way to identify if that particular version is correct. On properly formatted claim forms, there will be an approximate ¼-inch gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

New Frequently Asked Questions (FAQs) Posted

CMS has posted new "National Provider Identifier (NPI) Frequently Asked Questions (FAQs)" on its Web site. To view these FAQs, visit the NPI area of the CMS Web site at (**www.cms.hhs.gov/NationalProvIdentStand**) and click "Educational Resources." Scroll down to the "Related Links Inside CMS" area and click "Frequently Asked Questions." Then to find the latest FAQs, click the arrows next to "Date Updated."

Dental Benefits for Pregnant Women

This article originally ran in the March and April Medi-Cal Updates.

On October 7, 2005, the Governor signed SB 377, which directed the California Department of Health Services (CDHS) to immediately provide coverage of certain non-emergency dental benefits, described below, for pregnant Medi-Cal recipients. Prior to enactment of this legislation, these benefits were only available to pregnant women in the following restricted aid codes: 44, 48, 5F and 58 (see the November 2002 *Medi-Cal Update* and *Denti-Cal Bulletin*, Vol. 18, No. 19, October 2002).

Enactment of SB 377 requires immediate implementation of these same benefits for pregnant women in the following fifteen *additional* existing aid codes: 0U, 0V, 3T, 3V, 55, 5J, 5R, 5T, 5W, 6U, 7C, 7G, 7K, 7N and 8T (see *Denti-Cal Bulletin*, Vol. 21, No. 41, December 2005). These benefits were added because of recent scientific evidence showing an association between periodontal disease in pregnant women and adverse birth outcomes. **These benefits may help prevent pre-term delivery and low birth weight; they are important for the health of both the mother and the newborn. If a pregnant patient is not currently under the care of a dentist, providers are encouraged to refer her to one during her pregnancy.**

Billing Update for FQHC, RHC and IHS Recipients

With respect to the dental services listed below that are provided to pregnant women in the fifteen additional aid codes by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or Indian Health Services (IHS), EDS will automatically reprocess and adjust denied claims with the above-mentioned criteria retroactive to dates of service on or after October 7, 2005.

Dental Benefits *(continued)*

The following aid codes are now eligible for this expanded coverage:

Code	Benefits	SOC	Program/Description
0U	Restricted Services	No	BCCTP – Undocumented Aliens. Provides emergency, pregnancy-related and Long Term Care (LTC) services to females younger than 65 years of age with unsatisfactory immigration status who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with creditable insurance. State-funded cancer treatment services are covered every18 months (breast) and 24 months (cervical). *Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).*
0V	Restricted services	No	Post-BCCTP. Provides limited-scope no SOC Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services for females younger than 65 years of age with unsatisfactory immigration status and without creditable health insurance coverage who have exhausted their 18-month (breast) or 24-month (cervical) period of cancer treatment coverage under aid code 0U. No cancer treatment. Continues as long as the woman is in need of treatment and, other than immigration, meets all other eligibility requirements. *Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).*
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC). Provides six months of coverage for eligible aliens without satisfactory immigration status who have been discontinued from Section 1931(b) due to increased earnings from employment.
3V	Restricted to pregnancy and emergency services	No	AFDC – 1931(b) Non CalWORKS. Covers those eligible for the Section 1931(b) program who do not have satisfactory immigration status.
44	Restricted to Pregnancy-related services	No	200 Percent FPL Pregnant (Income Disregard Program – Pregnant). Provides eligible pregnant women of any age with family planning, pregnancy-related and postpartum services if family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	200 Percent FPL Pregnant Omnibus Budget Reconciliation Act (OBRA) (Income Disregard Program – Pregnant OBRA). Provides eligible pregnant aliens of any age without satisfactory immigration status with family planning, pregnancy-related and postpartum, if family income is at or below 200 percent of the federal poverty level.

Dental Benefits *(continued)*

5F	Restricted to pregnancy and emergency services	Y/N	OBRA Alien – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status.
5J	Restricted to pregnancy and emergency services	No	SB 87 Pending Disability Program.
5R	Restricted to pregnancy and emergency services	Yes	SB 87 Pending Disability Program.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC. Provides an additional six months of emergency services coverage for those beneficiaries who received six months of initial TMC coverage under aid code 3T.
5W	Restricted to pregnancy and emergency services	No	Four-Month Continuing Pregnancy and Emergency Services Only. Provides four months of emergency services for aliens without satisfactory immigration status who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
55	Restricted to pregnancy and emergency services	No	OBRA Not PRUCOL – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA and IRCA* section in this manual. *Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).*
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers eligible aliens who do not have satisfactory immigration status.
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled. Covers the disabled in the Aged and Disabled FPL program who do not have satisfactory immigration status.

Dental Benefits *(continued)*

Code	Benefits	SOC	Program/Description
7C	Restricted to pregnancy and emergency services	No	100 Percent OBRA Child. Covers emergency and pregnancy-related services to otherwise eligible children, without satisfactory immigration status who are ages 6 to 19, or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care. This option allows the Qualified Provider (QP) to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive. QP issues paper PE ID Card.
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC). Provides emergency and pregnancy-related benefits (no Share of Cost) to children without satisfactory immigration status who are up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7N	Valid for Minor Consent services	No	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to services related to pregnancy and family planning. Paper Medi-Cal ID card issued.
8T	Restricted to pregnancy and emergency services	No	100 Percent Excess Property Child – Pregnancy and Emergency Services Only. Covers emergency and pregnancy-related services only to otherwise eligible children without satisfactory immigration status who are ages 6 to 19, or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.

Emergency dental procedures are already available to individuals in the aid codes listed above. For a list of the emergency dental procedures, see *Denti-Cal Bulletin* Vol. 21, No. 41, December 2005 (**www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_21_Number_41.pdf**).

The procedures that have been added <u>for pregnant women only</u> are the following:

010   Examination, initial episode of treatment only

015   Evaluation, periodic

049   Prophylaxis, recipients younger than 12 years of age

050   Prophylaxis, recipients 13 years of age and older

062   Prophylaxis, including topical application of fluoride, recipients ages 6 through 17

452   Subgingival curettage and root planing per treatment

453   Occlusal adjustment (limited) per quadrant (minor spot grinding)

472   Gingivectomy or gingivoplasty per quadrant

473   Osseus and mucogingival surgery per quadrant

474   Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)

If the recipient/patient has questions regarding Denti-Cal, please refer her to the Denti-Cal Beneficiary Toll-Free Line: (800) 322-6384.

New Policy and Frequency Restrictions for HIV Drug Resistance Testing

Effective June 1, 2007, a new frequency restriction of 40 drug tests per 12-month period for the same patient has been added to CPT-4 code 87904 (phenotype, DNA HIV test add). In addition, new documentation requirements have been added to code 87904, as well as codes 87901 (genotype, DNA HIV Test) and 87903 (phenotype, DNA HIV Test).

> **Reminder:** Any combination of codes 87901 and 87903 is limited to four tests per 12-month period.

In order for a claim to meet the new documentation requirements, a provider must document at least one of the following three conditions and also include the most recent HIV viral load and test date. The three new conditions that must be correctly documented in the *Reserved for Local Use* field (Box 19) of the claim form or as an attachment for reimbursement for any of the above-mentioned CPT-4 codes are as follows:

- Recipients with treatment failure following a combination of highly active antiretroviral therapy (HAART), which is defined as:

  — Virologic (failure to achieve a viral load of less than 400 copies/ml at 24 weeks, or more than 50 copies/ml after 48 weeks, or a repeat viral load of more than 400 copies/ml after prior suppression of viremia to less than 400 copies/ml, or

  — Immunologic (failure to increase CD4 count by 50 cells/mm^3 over baseline during the first year of treatment), or

  — Clinical (HIV-related disease progression after at least three months of HAART); or

- Treatment-naive patients with acute or chronic HIV infection; or

- Pregnant women with HIV infection prior to initiation of therapy or for those entering pregnancy with detectable HIV ribonucleic acid levels.

In addition to documenting one of the above conditions, the most recent HIV viral load, including the test date, must also accompany the claim when billing for one of the above-mentioned CPT-4 codes.

Failure to provide the required documentation for 87901, 87903 and 87904 will result in claims being denied.

Drug resistant testing is not to be performed in either of the following clinical situations:

- If the plasma HIV-1 RNA level is below 500 copies/ml, because resistance tests with viral loads of less than 500 cannot be reliably performed or interpreted.

- After more than four to six weeks of discontinuing anti-retroviral drug therapy, because reversion to "wild type" virus by this time makes interpreting resistance tests unreliable.

This information is reflected on manual replacement pages path micro 4 thru 7 (Part 2).

Paramagnetic Contrast Materials Policy Update

Effective for dates of service on or after June 1, 2007, a *Treatment Authorization Request* (TAR) is no longer required for the following HCPCS codes:

HCPCS Code	Description
Q9952	Injection, gadolinium-based magnetic resonance contrast agent, per ml
Q9953	Injection, iron-based magnetic resonance contrast agent, per ml

HCPCS codes Q9952 – Q9954 are separately reimbursable for Magnetic Resonance Imaging (MRI) or Magnetic Resonance Angiography (MRA) procedures.

Additionally, "Non-Ionic Radiographic Contrast Media Guidelines" is revised to read "Low Osmolar Radiographic Contrast Media Guidelines" in the *Radiography: Diagnostic* section of the Part 2 manual.

This information is reflected on manual replacement pages radi dia 18 thru 20 (Part 2).

Sodium Hyaluronate Injections Frequency Restriction Update

Effective for dates of service on or after June 1, 2007, HCPCS code X7484 (Synvisc 2 ml) is reimbursable for one series of three weekly injections per knee (one injection, one week apart, for a total of three weeks) every six months. HCPCS codes X7482 (Hyalgan 2 ml) and X7486 (Supartz 25 mg) are reimbursable for one series of five weekly injections per knee (one injection, one week apart, for a total of five weeks) every six months.

When submitting a *Treatment Authorization Request* (TAR), providers must indicate if the injections are being given bilaterally. When one knee has been treated and the procedure reimbursed with an approved TAR, subsequent treatment of the opposite knee will require a separate TAR.

This information is reflected on manual replacement page <u>inject 42</u> (Part 2).

Billing Limitation for Select Radiation Treatment Services

Effective for dates of service on or after June 1, 2007, the following radiology codes must be billed with modifier TC (technical component) only. No reimbursement will be made for the professional component (modifier 26) for these codes.

CPT-4 Code	Description
77401	Radiation treatment delivery, superficial and/or ortho voltage
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	6-10 MeV
77404	11-19 MeV
77406	20 MeV or greater
77407	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	6-10 MeV
77409	11-19 MeV
77411	20 MeV or greater
77412	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
77413	6-10 MeV
77414	11-19 MeV
77416	20 MeV or greater

This information is reflected on manual replacement pages <u>radi 5</u> (Part 2) and <u>radi onc 2</u> (Part 2).

Solano County Added to Children's Treatment Program List

Solano County has been added to the list of contract counties eligible for payment through the Children's Treatment Program (CTP) for claims with dates of service on or after July 1, 2006.

This information is reflected on manual replacement page <u>children 1</u> (Part 2).

RhuEPO Therapy Target Correction

A previously published table showing the therapy target for recombinant human erythropoietin (RhuEPO) was inconsistent with corresponding medical necessity documentation. The target was previously listed as:

Hct $\leq$ 39% and/or Hgb 13g/dl.

The "less than or equal to" symbol has been removed from this statement. The corrected information is as follows:

RhuEPO (Epogen and Procrit) Therapy Target	Medical Necessity Documentation
Target: Hct 39% and/or Hgb 13g/dl	Medical justification for the higher target such as, but not limited to, ischemic heart disease or congestive heart failure

This information is reflected on manual replacement pages <u>inject 14 and 16</u> (Part 2) and the <u>Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements</u> form (Part 2).

Anesthesia Time Billing Reminder

When billing for anesthesia time units, providers are reminded to enter the units and <u>not the minutes</u> on the claim form. Each 15-minute increment of anesthesia time equals one time unit. To bill anesthesia time units, enter the number of 15-minute increments of anesthesia time in the *Days or Units* box on the claim form, using the same billing line as the procedure code. Increments of time less than five minutes are not reimbursable except when the total anesthesia time being billed is less than five minutes.

For more information, refer to the *Anesthesia* section in the appropriate Part 2 manual.

CLIA Reminder for Laboratory Providers

Providers are reminded that all clinical laboratories, including reference laboratories and out-of-state providers seeking reimbursement for clinical laboratory tests or examinations, must have the appropriate Clinical Laboratory Improvement Act (CLIA) certification in order to be correctly reimbursed for laboratory procedures. If the clinical laboratory does not have the appropriate CLIA certification for the test or examination billed, or is not certified in the appropriate subspecialties, the claim will be denied.

More information about CLIA certifications is available on the Centers for Medicare & Medicaid Services (CMS) Web site at **www.cms.hhs.gov/CLIA**.

Lab Claims: Multiple Procedures Billing Reminder

When billing for multiple laboratory procedure codes on the same claim, providers are reminded to use a single claim line to bill the same laboratory procedure, more than once, on the same day. For example, the same laboratory procedure may be performed more than once on a single date of service to establish a diagnostic "curve," as in stimulation or provocative tests. These laboratory procedures should be billed as a single claim line rather than line billing each test. Providers should indicate in the *Days* or *Units* field to identify the number of times each specimen was drawn or obtained.

For more information, including a billing example, refer to the *Pathology Billing Example: CMS-1500* section in the Part 2 manual.

Reminder for Add-On Laboratory Procedure Codes

CPT-4 codes 88141 (cytopathology, cervical or vaginal [any reporting system], requiring interpretation by physician) and 88155 (cytopathology, slides, cervical or vaginal, definitive hormonal evaluation [eg, maturation index, karyopyknotic index, estrogenic index] [list separately in addition to code(s) for other technical and interpretation services]) are separately reimbursable when billed in conjunction with various pap smear codes (88142 – 88154, 88164 – 88167 and 88174 – 88175) for the same recipient, any provider, and same dates of service and when medically justified.

This information is reflected on manual replacement page <u>path cyto 1</u> *(Part 2).*

Family PACT Policy Updates for CPT-4 Code 88141

Effective for dates of service on or after June 1, 2007, CPT-4 code 88141 (cytopathology, cervical or vaginal [any reporting system], requiring interpretation by physician) is separately reimbursable when billed in conjunction with various pap smear codes (88142, 88143, 88147, 88148, 88164, 88165, 88167, 88174 and 88175) for the same recipient, any provider, and same dates of service when medically justified and documented in the *Reserved for Local Use* field (Box 19) of the claim or on an attachment.

In addition, the frequency limit for code 88141 is changed from once daily to once in 30 days.

New Health Access Program Card Numbering Format

The Family PACT (Planning, Access, Care and Treatment) Program is printing a new inventory of Health Access Programs (HAP) client identification cards with a change in numbering format. The current HAP cards use a 10-digit alphanumeric format beginning with the number "9" and the suffix letter "Y." New inventory will be identified with the suffix letter "X." During HAP card transactions, providers should not attempt to manually override the new alphanumeric format.

As current supplies of HAP cards are depleted, the newly formatted cards will be released to enrolled Family PACT providers. For additional information about HAP cards and new distribution quantity guidelines, please see the "Program Letters" page of the Family PACT Web site at **www.familypact.org/providers/program-letters**.

Provider Orientation and Update Session

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The date for an upcoming session is listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation *(continued)*

Please note the upcoming Provider Orientation and Update Session below.

> ***Oakland***
> **June 7, 2007**
> **8:30 a.m. – 4:30 p.m.**
> Park Plaza Hotel
> 150 Hegenberger Road
> Oakland, CA 94621
> (510) 635-5000

For a map and directions to this location, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location.

Registration
To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site (**www.familypact.org**).

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Addition, effective March 23, 2007

Drug	Size and/or Strength
LAPATINIB	
Tablets	250 mg

Addition, effective May 1, 2007

Drug	Size and/or Strength
* CARVEDILOL PHOSPHATE	
Extended release capsules	10 mg
	20 mg
	40 mg
	80 mg
* Restricted to use for the treatment of mild to severe heart failure. (Labeler Code 00007 [GlaxoSmithKline Group of Companies] only.)	

Change, effective April 2, 2007

Drug	Size and/or Strength
* TEGASEROD	
Tablets	2 mg
	6 mg
* Restricted to use in women with irritable bowel syndrome whose primary bowel symptom is constipation **with dates of service on or between March 1, 2003 and April 1, 2007.**	

Change, effective May 1, 2007

Drug	Size and/or Strength
* METOPROLOL SUCCINATE	
+ Tablets, extended-release	25 mg
	50 mg
	100 mg
	200 mg
*** (NDC Labeler Code 00186 [AstraZeneca LP] only.)**	

+   Frequency of billing requirement

Obstetrics Bulletin 395

Remove and replace: cal child sar 5/6 *
                             cal child ser 1/2 *
                             children 1/2
                             cms sub 1/2 *
                             inject 13 thru 16, 41/42

Remove and replace
after the *Injections* section: *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements*

Remove and replace: medi cr cms 3/4 *
                             path cyto 1/2

Remove: path micro 3 thru 6
Insert: path micro 3 thru 5

Remove: radi 3 thru 8
Insert: radi 3 thru 7

Remove and replace: radi dia 17 thru 20
                             radi onc 1 thru 3

*   Pages updated due to ongoing provider manual revisions.